Application for Children's Medical Programs

Effective June 1, 2005

Kids Connection

Instructions: Read carefully. Please write clearly.

*Required field **This is not a valid application until it contains your name, address and signature.**

IF YOU OR YOUR CHILDREN ARE RECEIVING OR HAVE APPLIED FOR MEDICAID DO NOT FILL OUT THIS FORM

*Person Applying for the Child or Children		*Relationship	Social Security Number *(if available)*	
*Address (Number, Street)	*City	*Zip Code	*County	*Telephone/Home or message phone
Mailing Address, if different (Number, Street)		City	Zip Code	Telephone/Work

Did anyone in your household receive services through the Department of Health and Human Services this month or last month?
(For example: Food Stamps, ADC, Child Care, Medicaid, Energy Assistance, etc.) ☐ Yes ☐ No
If yes, explain under what name, where, when and type of services:

*What is the primary language spoken in your household?

List everyone in your family who lives with you (parents & children). Give the information listed. Use more paper if you need to.

*Name: (First Name, Middle Initial, Last Name)	U.S. Citizen Legal Alien Y/N	Social Security Number	Race	Birthdate (m/d/yyyy)	Sex M/F	*Pregnant Y/N	*If Pregnant, What is Expected Due Date? Provide doctor's statement
Parents in Home (Biological, step or adoptive) Include Pregnant Minors							

*Children	*U.S. Citizen Legal Alien Y/N	*Social Security Number	Race	*Birthdate (m/d/yyyy)	*Sex M/F	*Mother's Name	*Father's Name	*Attend School Y/N

Do you currently have insurance? ☐ Yes ☐ No If yes**,** tell us the name of your insurance company, the policy number and the names of everyone covered on the policy. The cost of health insurance premiums may be deductible from countable income.

*Insurance Company	*Phone Number of Company	*Policy Number or Group Plan Number	*Type of Coverage (HMO, full coverage, vision, etc.)	*Names of Family Members covered by Policy

Did any of your children living with you have unpaid medical bills in the past 3 months? ☐ Yes ☐ No
If yes, you may be able to receive help paying these bills.

Attach Copies of Pay Stubs and Complete Information Below

We need proof of your income. For earnings, provide copies of **PAY STUBS FOR THE LAST FULL MONTH**. If you do not have pay stubs, you may provide a letter from your employer. If you are self employed, provide a copy of your most recent federal income tax return. Other documents can be used, such as a letter from your employer. If you have questions, call toll-free at 1-877-632-5437.

Does any Adult or Child Currently Receive any Money From:	No	Yes	*If Yes Who Is It?	*Employer Name or Income Source	*Gross Amount	*How Often Received?
Salaries, Wages, Tips, Commissions, etc., (Provide pay stubs for each adult)						
Self-Employment Income - (Include 1040 and appropriate Schedules)						
Unearned Income Such As: Veteran's Benefits, Child Support/Alimony, Spousal Support, Interest, Dividends						
Unearned Income Such As: Unemployment Compensation, Worker's Compensation, Social Security, SSI						

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(previous version 6/04 should be used first)

If you pay day care costs, please give names of the children and the monthly amount you pay for each child.

*Name of Child	*Monthly Amount	*Name and Address of Provider

Do you want to receive Information about additional help with: (check applicable boxes) ☐ Money ☐ Food ☐ Utilities ☐ Rent/Shelter ☐ Child Care ☐ Transportation ☐ Adult Care ☐ Help in your Home ☐ Other_____

PLEASE SIGN THIS STATEMENT: I certify that the information I have provided above is true to the best of my knowledge and I give permission for the State of Nebraska to make any necessary contacts to check my statements. I have read the list of my rights and responsibilities that is printed below. I know that I could be penalized if I knowingly give false information. I certify that the children listed on this application are U.S. citizens or legally admitted aliens.

***Signature or Mark of Applicant:**_____ ***Date:**_____
(Witness if mark)

Mail this completed, signed form, together with proof of income, to:
Kids Connection, P.O. Box 94926, Lincoln, NE 68509-4926.

If you need more information, please call the toll-free number 1-877-NEB-KIDS (1-877-632-5437) or 402-471-8845.

Rights and Responsibilities

If you need assistance with food, utilities, day care or other needs contact your local Department of Health and Human Service Office.

1. I know that my children under age 19 who are eligible for Medicaid/Kids Connection can have free health checkups under a child health prevention program called Health Check (EPSDT).
2. I know that the information I have given is confidential. I agree that medical information about my children can be released only if needed to administer this program.
3. I know that any information I have given may be reviewed and verified by the State of Nebraska. Also, I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permissions are needed to get verification or other information.
4. I know that this application will be considered without regard to race, color, sex, age, handicap, religion, national origin or political belief.
5. I know that I may ask for a hearing if I am not satisfied with any action taken by the State of Nebraska in connection with the program. I may also ask for a hearing if I feel that I have been discriminated against.
6. I know that the State of Nebraska will request and use information from a computer system called the State Income and Eligibility Verification System (IEVS). This computer system compares the Kids Connection information about me and other members of my family with information from other agencies. Other agencies may include the Internal Revenue Service, Social Security Administration, Department of Labor, Veterans Administration and Vital Statistics.
7. I know that Kids Connection does not pay medical expenses that a third party, such as a private health insurance company, is supposed to pay if my children get Kids Connection. I give my rights to any third party payments to the Department of Health and Human Services. These payments may include payments from hospital and health insurance policies. I know that if I refuse to give my rights to third party payments to the Department of Health and Human Services, I will not be eligible to receive Medicaid.

I understand that this application is an application for one kind of children's health benefits under Medicaid and is not a full Medicaid application. I understand that if my children are not found eligible for this children's health benefits program under Medicaid, I may be eligible for Medicaid benefits on some other basis and have a right to complete a full Medicaid application.

Income Computation: FOR AGENCY USE ONLY

1. Total Monthly Gross Earned Income	$_____	4. Subtract $100 from Line 3 for each employed adult	$_____
		5. Total Child Care Costs	$_____
2. Total Net Self-Employment Income	$_____	6. Net Earned Income (Subtract 5 from 4)	$_____
3. Total Earned Income (Add lines 1 & 2)	$_____	7. Total Monthly Unearned Income	$_____
		8. Total Countable Income (Add 6 & 7)	$_____

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

The Nebraska Health and Human Services System promotes and values diversity. It is committed to affirmative action/equal employment opportunities and does not discriminate in delivering benefits or services.